Maximizing and simplifying enrollment: options for Maryland

Health Care Reform Coordinating Council

Entry into Coverage Workgroup

August 31, 2010

Stan Dorn, Senior Fellow

The Urban Institute

Washington, DC

Overview

- The importance of proactive strategies to enroll the eligible uninsured
- Success stories from other state and federal programs
- Policy options for Maryland

Part I

The importance of proactive strategies to maximize enrollment

If you build it, will they come? Not necessarily…

- Recent federal history
  - High-risk pools
  - COBRA subsidies
  - HCTC
- Older federal history
  - CHIP – after 5 years, only 60% of eligible children were enrolled
  - MSP – decades after statutory enactment, less than 33% of eligible seniors enroll
- State history
  - Maine

Part II

Success stories from other state and federal programs

The Massachusetts story

Findings from a SHARE grant funded by the Robert Wood Johnson Foundation

Urban Institute

Key facts

- Only 2.6 percent uninsurance by 2008
- But it's not just the mandate and the subsidies!
  - Consumers seamlessly enrolled into 4 separate programs. 1 form and 1 eligibility process applied to all programs.
  - Roughly 1 in 4 newly insured qualified for Commonwealth Care based on eligibility records from the state's free care pool—no applications needed!
  - More than half of all successful applications were filled out by CBOs and providers, not by consumers.
    - No DSH money for serving a patient unless application process completed
    - The "Virtual Gateway" – on-line application system open to trained staff of CBOs and providers

The Louisiana story

Urban Institute

LaCHIP renewals for children

- In December 2009:
  - Procedural terminations – 0.7 %
  - Total terminations – 4.6%
- By contrast:
  - In some states, 50 percent of children lose coverage at renewal
  - 40 percent of eligible, uninsured children nationally received Medicaid or CHIP the prior year
  - Why? Coverage ends unless renewal forms are completed
- LA eligibility determined based on
  - Data from state-accessible records
  - Where income is stable, administrative renewal
  - Proactive telephone calls
  - Traditional form completion is a last resort
- In September 2009, forms were required for only 3% of LA children renewing coverage

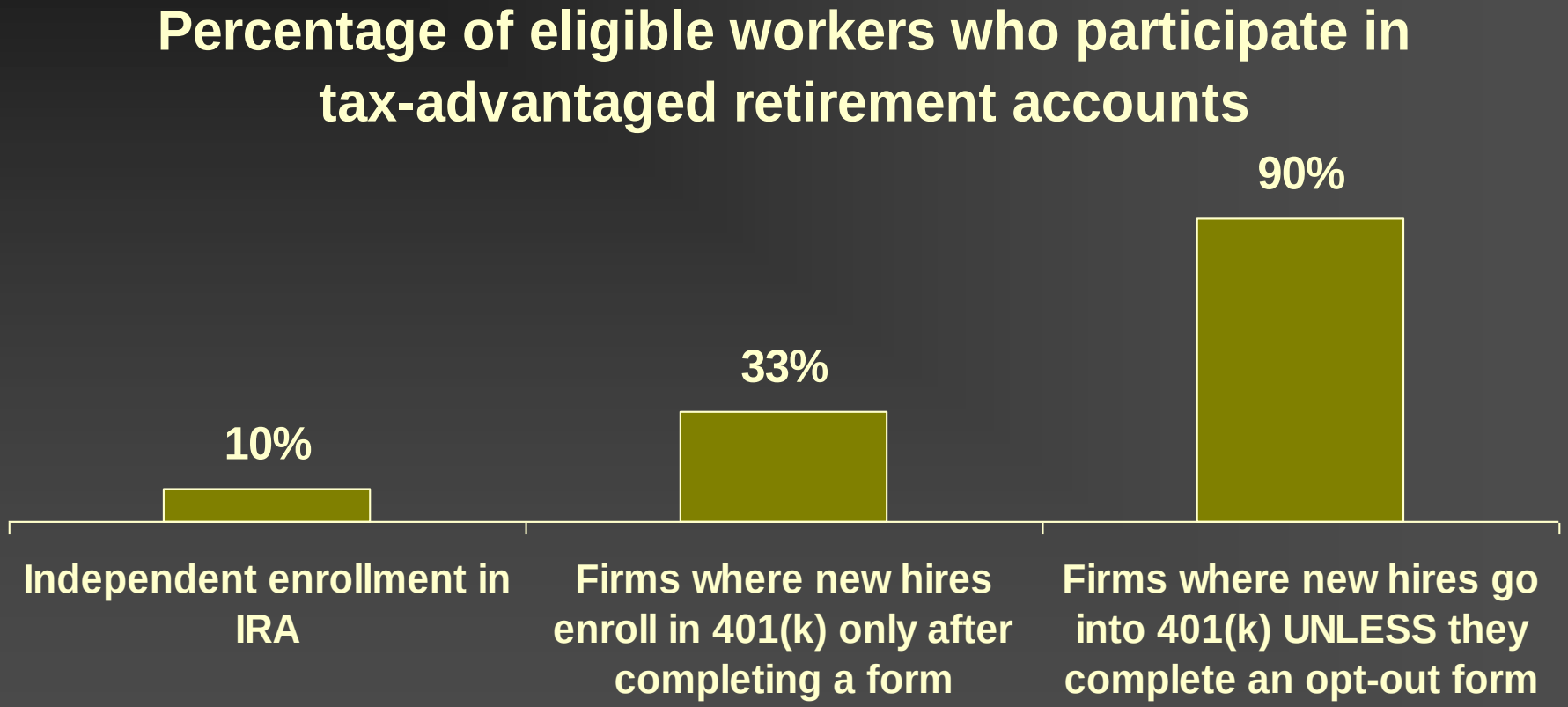
The Medicare Part D story

- 1/2006, Part D coverage of prescription drugs began
  - Included low-income subsidies (LIS)
- By 6/16/06, 74% of eligible beneficiaries received LIS
  - Most qualified based on data matches with state Medicaid programs or SSA
  - People who received Medicaid last year automatically get LIS this year
- Now, 80% of eligible beneficiaries receive LIS

Lessons learned

- Affordability is key
- The less consumers must do to enroll, the more will enroll
  - Base eligibility on data, without requiring the completion of traditional application forms
  - When forms are required, provide intensive application assistance, so consumers don't need to complete paperwork

Why is paperwork such an issue? Human nature.



Sources: Etheredge, 2003; EBRI, 2005; Laibson (NBER), 2005.

Urban Institute

Part III

Policy options for Maryland

Highlights of the Affordable Care Act (ACA): A quick review

- Medicaid to 138% of the federal poverty level (FPL)
  - Modified Adjusted Gross income (MAGI)
  - Rules for newly eligible adults
    - Definition: would not have qualified under state rules as of 12/1/09
    - Highly enhanced federal medical assistance percentage (FMAP) – 100% for 3 years, declining to 90% by 2020
    - "Benchmark benefits"
  - Standard FMAP and benefits for other adults
- Subsidies in the exchange up to 400% FPL
  - OOP cost-sharing subsidies to 250% FPL
- Integrated eligibility system for Medicaid, CHIP and exchange – 1 application form for all subsidies
- Individual mandate for coverage

Consumer assistance, including facilitated enrollment

- Consumer assistance grants for 2010
- Patient navigators in exchange
  - Federal funding through 12/31/14
  - Starting in 1/15, surcharge insurers?
  - Key questions:
    - How much funding for navigators? Can foundations help?
    - Who are the navigators? CBOs, legal services programs
    - What do navigators do? Fill out applications, via “virtual gateway”
- Outstationed EWs probably less effective
- Follow MA precedent in terms of safety net providers?
- New importance of consumer advice
  - Penalties for going without coverage
  - Tax consequences for excess subsidies

Basing eligibility on income data

- Subsidies in exchange
  - Based on prior-year tax data
  - Chance to supplement at application
  - Year-end reconciliation
- Medicaid
  - Initial determination based on income at time application is processed - challenge
  - Post-application changes? Not clear, under PPACA
  - What happens if application submitted to exchange?

Possible approach to Medicaid

- If prior-year tax data show Medicaid eligibility, consumer automatically receives Medicaid
  - If after a certain point in the calendar year, could supplement with more recent data (new hires, quarterly earnings)
- If prior-year tax data show ineligible for Medicaid, receive an opportunity to apply for Medicaid using traditional procedures, including pay stubs, etc. Like Express Lane Eligibility.
  - In the meantime, subsidies in the exchange
- Incidental advantages
  - Lower administrative costs for eligibility determination. 50% FMAP.
  - Less risk of erroneous eligibility determinations, federal sanctions.
- Depends on CMS allowing this approach – likely, not certain

Limit application forms to questions relevant to eligibility

- Need to distinguish the newly eligible from others
  - Claim enhanced FMAP
  - Provide benchmark benefits
- Requires information irrelevant to eligibility
  - Parents
    - Assets
    - Deprivation
  - Childless adults and empty nesters
    - Disability
    - Pregnancy

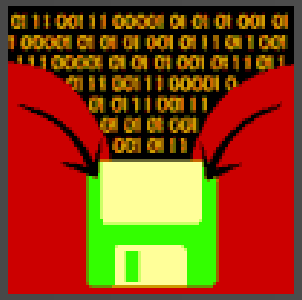
- Solutions
  - To claim FMAP, use sampling (assuming CMS approval)
  - Provide standard Medicaid benefits as “Secretary-approved” benchmark coverage, Social Security Act Section 1937(b)(1)(D)

Asking for help without completing a traditional form

- Eligibility is determined based on data when an individual applies "by requesting a determination of eligibility and authorizing disclosure of … information [described in Social Security Act Sections 1137, 453(i), and 1942(a)] … to applicable State health coverage subsidy programs for purposes of determining and establishing eligibility." PPACA Section 1413(c)(2)(B)(ii)(II)
- Precedents
  - EITC amount
  - CA income tax
  - Medicare Parts B and D – automatic, without request

Process

- Consumer requests determination of eligibility based on disclosure of data
- State and exchange gather data.
  - SSA Section 1137 – IEVS, SAVE
  - 453(i) – National Directory of New Hires
  - 1902(a) – public benefit programs, new hires data, state tax records, Medicaid TPL data showing private coverage, vital statistics records in any state
- Data establish:
  - Medicaid eligibility
  - Eligibility for subsidies in exchange, with right of consumer to seek Medicaid determination based on more recent information



Basing eligibility on receipt of other benefits

- Express Lane Eligibility (ELE) remains an option for children
- Can seek 1115 waiver for adults
- Logical if other program's eligibility is below 138% FPL. For example:
  - SNAP (130% gross income)
  - TANF ($565/month, less deductions)
- Depends on CMS approval – likely, not certain

Integrated eligibility determination

- Basic model
  - Exchange, Medicaid, and CHIP compile a data warehouse for each applicant, determine eligibility “behind the scenes”
- Medicaid needs better eligibility IT
  - Will CMS develop modules?
  - Will CMS provide sufficient Medicaid funding?
  - Can administrative funding for the exchange help with Medicaid?
- Exchange can contract with Medicaid to determine eligibility for subsidies in exchange
  - Massachusetts model
  - Must meet HHS “requirements ensuring reduced administrative costs, eligibility errors, and disruptions in coverage”
- Single, statewide office when data establishes eligibility
  - Link to local social service offices when households may qualify for other benefits

But can low-income adults afford coverage in the exchange? Will they enroll? Will they seek care?

- Subsidy levels lower than almost any state program serving low-income adults
- Example: single adult at 160% FPL, $1,444 in monthly pre-tax income. Under PPACA:
  - $64 in monthly premiums
  - Copays could include
    - $20 per office visit
    - $10, $25 and $40 per prescription
  - Contrast: most CHIP programs impose no charges or minimal charges at this income level. Same is true of longstanding state programs for adults at this level.

Basic health program (BHP)

- Covered individuals
  - Income at or below 200% FPL
  - Ineligible for Medicaid or CHIP because of
    - Income; or
    - Legalization of immigration status during the past 5 years.
- State
  - Contracts with health plans to provide coverage at least as generous as in the exchange
  - Receives 95% of what the federal government would have spent in subsidies
- State could use BHP to provide Medicaid look-alike coverage
  - Federal dollars typically much higher than Medicaid pmpm
  - Could use excess to raise reimbursement, improve access
    - Equity and targeting issues

Conclusion

- No matter what, ACA is likely to dramatically increase coverage and access to care
- The amount of that increase will depend, in significant part, on state policy decisions
- Maryland can be a national leader